

PRESCRIBER'S SIGNATURE:

New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form Fax: 1-888-603-7696 Phone: 1-866-675-7755

Hepatitis C Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED	
Patient's Name	Medicaid Number
Date of Birth (MM/DD/YYYY) Gender	
/ Male Female	
Drug Name	Strength
Dosing Directions	Length of Therapy
SECTION II: CLINICAL HISTORY	
1. Does the patient have a diagnosis of Hepatitis C?	☐ Yes ☐ No
Document patient's genotype, starting HCV RNA assay result and date taken	
3. Does the patient have a diagnosis of HIV or cirrhosis? Please list:	
•	
4. Is the patient being treated for substance or alcohol abuse? Yes No If yes, tr	eatment confirmation
6. Has the patient tried/failed a protease inhibitor or Sovaldi in the past?	☐ Yes ☐ No
7. Will the patient be on concurrent therapy with Ribavirin and/or Peginterferon?	☐ Yes ☐ No
If approved, additional HCV RNA assay lab work may be required at week 4, 8, 12 and/or 24 de	pendent upon drug.
Request for Soyaldi only (complete the following section)	Process of the state of the sta
1. Is the patient intolerant to Interferon? Yes No If yes, Reason for intolerance	
Is there any additional information that would help in the decision-making process? If additional space is needed, please use another	
page	
If you are requesting a Non-Preferred product, proceed to Section III. If not, then proceed to Section IV.	
SECTION III: NON-PREFERRED DRUG APPROVAL CRITERIA	
Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the	
prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.	
Allergic reaction Drug-to-drug interaction. Please describe reaction:	
Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:	
Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide	
clinical information:	
Age specific indications. Please provide patient age and explain:	
Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:	
Unacceptable clinical risk associated with therapeutic change. Please explain:	
SECTION IV: PRESCRIBER INFORMATION	
Name and Speciality	NPI Number
Prescriber Phone Number Prescri	ber Fax Number
I certify that the information provided is accurate and complete to the best of my knowledge and I	understand that any falsification, omission, or
concealment of material fact may subject me to civil or criminal liability.	